# Quality Management Plan

# 1915 ( c ) Waiver

**North Carolina Department of Health and Human Services**
**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

## Preface

The North Carolina public system for mental health, developmental disabilities, and substance abuse services is in the third year of a five-year comprehensive restructuring and reform process that builds on reform legislation passed in 2001. Key components of this reform include:

- consumer involvement in system design and service planning, delivery and oversight
- an emphasis on home and community based services
- locally accountably and responsive service delivery systems
- clinically and financially effective services and supports based on evidence-based practices
- data-driven and outcomes-focused decision making

Key to the success of both the reform effort and the HCBS waiver is the development of a consumer-focused quality management system designed to:

- assure compliance with basic HCBS waiver requirements and standards
- track and facilitate progress toward system reform goals
- ensure the integrity and continuous improvement of services and
- support the achievement of desired outcomes and satisfaction for participants

Quality management (QM) in the NC MH/DD/SAS system has historically focused on *quality assurance* (QA) – ensuring compliance with waiver requirements as well as other state and federal statutes and administrative rules. Previous work and the restructuring of the system as part of reform have laid the groundwork for using consumer data to guide a *continuous improvement*-based approach to quality (QI). Future efforts will focus on creating structures, processes and mechanisms to facilitate rapid response to problems and system improvement over time.

Central to our efforts to strengthen our QM system is a Real Choice Systems Change Grant for QA/QI in HCBS awarded by CMS in 2003. The NC MH/DD/SAS service system is using this grant to accomplish the following goals:

- evaluate the process and outcomes of transitioning consumers from institutional to home and community–based care through data collected in face-to-face interviews with transitioning consumers, using other consumers and family members as interviewers
- develop a comprehensive, coordinated system of QI committees among provider agencies, local management entities and the NC DHHS
- use the transition interview data and QI committees to pilot ways to improve service delivery and consumer outcomes and satisfaction through QI processes
- develop a long-term plan for expanding the focus of the QI committees to encompass other populations, services, and processes

This document will address QA/QI processes that are currently taking place and future QA/QI processes in development or being planned as part of the CMS grant activities. The next section provides an overview of the organizational structure of the system and describes the primary units involved in QM. The remainder of the document is organized around the CMS regional review protocol components. HCBS Quality Framework domains are referenced within each section.

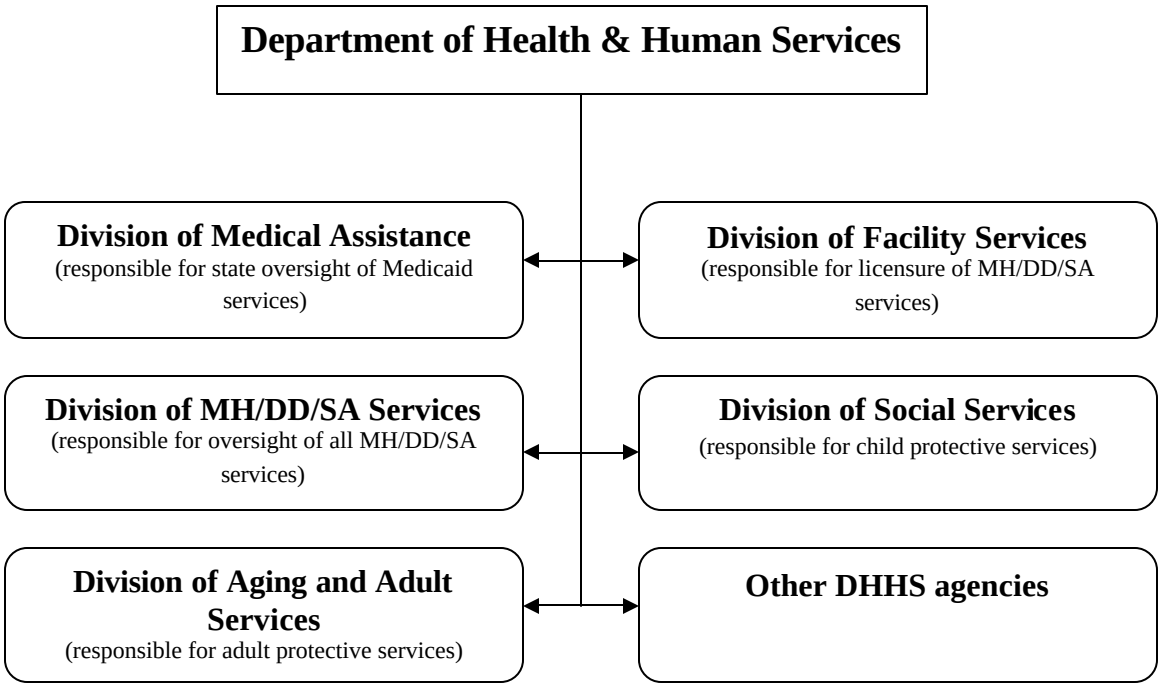
# Table of Contents

## Organizational Context for Quality Management

### State Authority for the Waiver

According to federal and state guidelines, the NC Division of Medical Assistance (DMA) has responsibility for the overall operation of the HCBS waiver. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) is the lead agency for overseeing the daily operations of this waiver. The two Divisions cooperate in the operation of the waiver program under a memorandum of understanding that delineates each Division's responsibilities. The Division of Facility Services (DFS), the Division of Social Services (DSS), and the Division of Aging and Adult Services (DOAAS) have legally mandated responsibilities for licensure of facilities (DFS) and for adult (DOAAS) and child protective services (DSS). All of these Divisions are under the authority of the Department of Health and Human Services (DHHS). These relationships are depicted on the chart in Figure 1 below.

Figure 1: NC Department of Health and Human Services



## Responsibilities of DHHS Divisions

### *Division of Medical Assistance*

DMA manages Medicaid for the state of North Carolina, and oversees the operation of waivers in relation to Federal and State guidelines. Program policies and procedures related to the waiver are developed in cooperation with DMA. DMA publishes and distributes manuals to provide guidance for Provider Agencies on enrollment, payment and related issues. Additional information and updates are provided through Medicaid bulletins available on the DMA web site.

### *Division of Facility Services*

In North Carolina, the Secretary of Health and Human Services is responsible for all licensing of health care facilities. Under NC General Statute 122C, the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, the Division of Facility Services (DFS) is responsible for licensing MH/DD/SAS facilities that provide residential and day services. [Homes in which only one adult lives and periodic services are not currently licensed.]. DFS also has responsibility to deny, suspend, amend or revoke a license in any case in which the Secretary finds a substantial failure to comply with licensure rules. Facilities are subject to DFS inspection at any time. DFS coordinates inspections and investigations with DMHDDSAS and its local management entities. DFS is also responsible for licensing all adult care homes in North Carolina.

### *Division of Social Services*

The Division of Social Services (DSS) is responsible for child protective services. In addition, DSS is responsible for licensing child foster care homes under NC General Statute 131D.

### *Division of Aging and Adult Services*

The Division of Aging and Adult Services (DOAAS) is responsible for adult protective services.

### *Division of Mental Health, Developmental Disabilities and Substance Abuse Services*

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) is responsible for developing and overseeing the provision of services to consumers with needs for mental health, developmental disabilities and substance abuse services. As part of this responsibility, DMHDDSAS is responsible for managing the daily operations and oversight of the CAP-MR/DD HCBS waiver services.

DMHDDSAS works in cooperation with DMA to develop and implement waiver policies, procedures, instructions and guidelines published and distributed in the form of a manual and official memoranda. The Division is responsible for publishing, maintaining, and distributing a program operations manual for use by local management entities (LME's), enrolled service providers, participants, and families, with manual content approved by DMA. (A copy of the manual is available free of charge to an individual or family member who requests one.) The Division also produces and disseminates the Service Records Manual, which describes service plan and documentation requirements, and Clinical Guidelines to guide practice in various clinical areas. All of these publications are available on the Division's web site.

As part of the reform effort, the MH/DD/SAS service system is designed as a three-tiered system. DMHDDSAS sets policy regarding MH/DD/SAS services and oversees local counties or groups of counties (called "local management entities" or "LME's") that in turn have responsibility for implementing state policy and overseeing services delivered by local provider agencies. Because of the Division's responsibility for managing and overseeing all MH/DD/SAS services, its explicit quality management processes for the HCBS waiver are included and integrated into the quality management procedures for all of the programs and funding sources under the responsibility of the Division.

DMHDDSAS Leadership

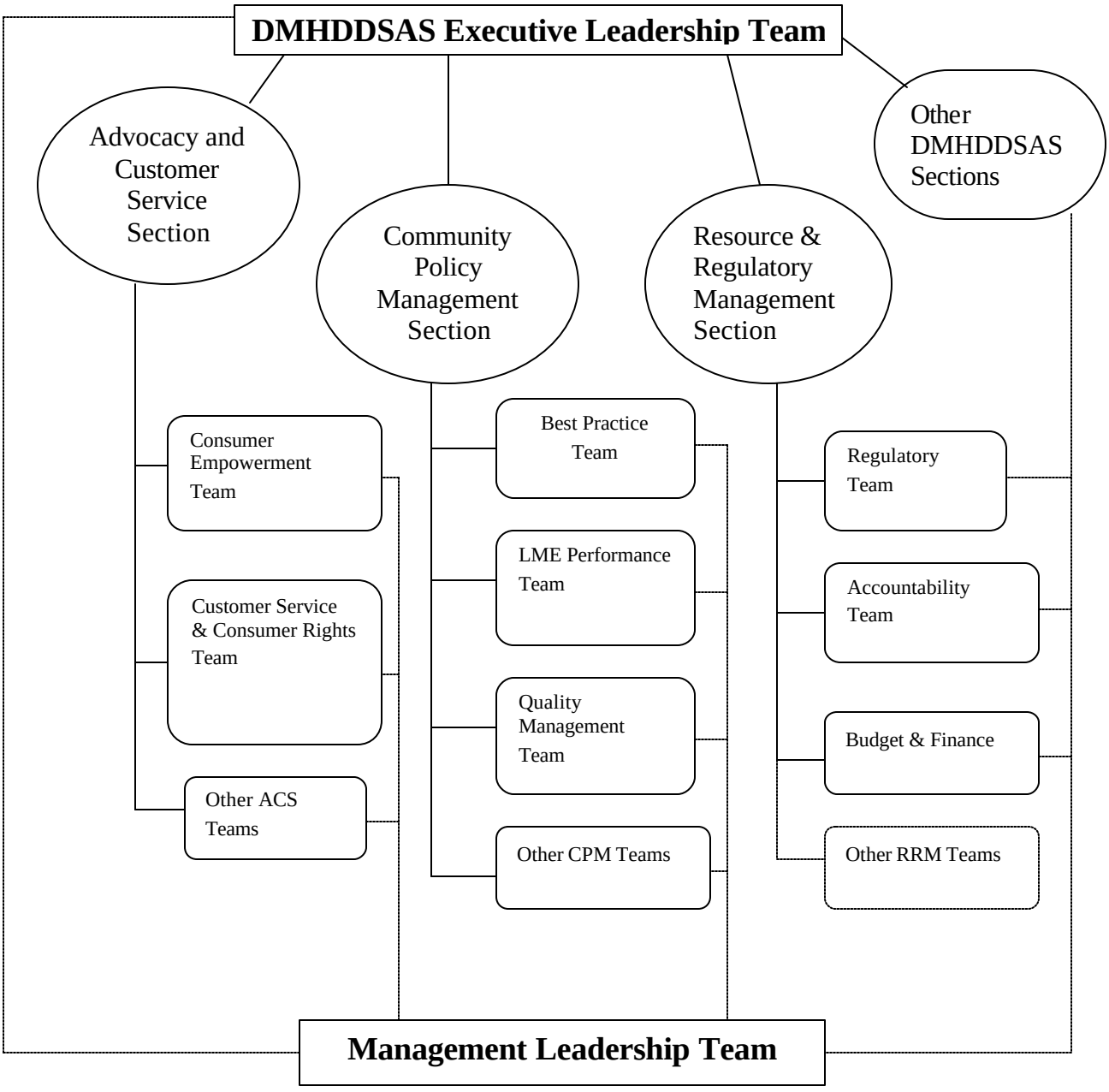
The DMHDDSAS leadership has primary responsibility for ensuring that this three-tiered approach protects the health, welfare and rights of consumers, adheres to the requirements of the waiver, and achieves the goals of the State Business Plan for MHDDSA Services.

*Executive Leadership Team (ELT).* The ELT is responsible for setting goals, policies, and the strategic plan for the system. This team is composed of the Division's Director, Deputy Director, Chief of Clinical Policy, and chiefs of the five sections within DMHDDSAS. It sets priorities for service improvement and system changes, oversees the implementation of the waiver, and approves all decisions regarding waiver and other services.

*Management Leadership Team (MLT).* The MLT is responsible for operationalizing and implementing the state's strategic plan. This team, composed of the leaders of the 20 teams within the Division's central office, also functions as the quality improvement committee for central office staff. As such, it is responsible for monitoring and evaluating progress on state reform goals, reviewing system performance data, and determining means of addressing problems and opportunities for improvement. This team has been in existence for one year and is still developing its role and processes in this regard.

Two Sections within DMHDDSAS have operational responsibility for ensuring the quality of HCBS waiver programs – the Community Policy Management (CPM) Section, which develops service policies, provider qualifications, and quality standards and the Resource and Regulatory Management (RRM) Section, which oversees fiscal and regulatory accountability. A third section, Advocacy and Customer Service (ACS), has responsibility for coordinating consumer involvement in service planning, delivery and oversight and managing complaints about access to and quality of services. Each of these Sections is divided into teams, with duties being coordinated with other teams in a matrix fashion. The teams within these sections with explicit responsibilities for quality management are depicted in Figure 2 and described below.

Figure 2: Quality Management in the NC Division of MH/DD/SA Services



Community Policy Management Section

*Best Practice Team (BP Team).* The Best Practice Team is responsible for improving and strengthening the system through development of conceptual foundations or platforms for practice. This includes continuously researching, compiling, disseminating, and advancing relevant emerging best practice and innovations in the areas of MH/DD/SAS, including waiver development. The role of the Best Practice Team is critical to insuring that policy in regard to waiver development supports the concepts espoused by the Centers for Medicare and Medicaid Services (CMS) that individuals: a) Live in the most integrated community setting appropriate to their support needs and preferences, b) Exercise meaningful choices about their living environment, service providers, types of supports, and the manner in which supports are provided, and c) Obtain quality services in a manner consistent with their preferences and priorities.

*LME Performance Team (LME Team).* The LME Team is responsible for overseeing responsibilities that are contracted to the LME's. The LME Team has 10 members who act as liaisons to the 29 LME's, and 4 programs that have not yet achieved certification as a LME (these numbers are subject to change as programs become LME's). These liaisons monitor the performance of LME's and coordinate giving LME's technical assistance, as needed from other Division staff members. The role of this team is crucial for ensuring accountability and quality for waiver services, given the three-tiered approach to MH/DD/SA services in NC.

*Quality Management Team (QM Team).* The QM Team has responsibility for setting performance standards for Local Management Entities (LME's) and service providers in the system as well as coordinating all Quality Improvement activities across the state. This team has eight members whose duties include data analysis and production of regular reports on local and state system performance, service cost and utilization, and consumer outcomes, incidents, and satisfaction. In addition this team is responsible for managing the Real Choice QA/QI grant and coordinating development of the state's QI system.

Resource/Regulatory Coordination and Management Section

*Regulatory Team.* This team is responsible for ensuring regulatory compliance by the Division in carrying out regulatory related services. Specific functions include but are not limited to completing provider enrollments, and providing interpretations of federal and state regulations. The Regulatory Team has lead responsibility for developing the CAP-MR/DD Manual and for coordinating with DMA and the Best Practice Team on waiver implementation and operation issues.

*Accountability Team*. The Accountability Team is responsible for monitoring implementation of Medicaid policy, state and local system performance, and compliance with waiver requirements and standards. The Accountability Team members perform regular on-site reviews at LME's and provider agencies and investigate problems in service provision. This team also makes recommendations to DMA regarding the enrollment of providers to deliver waiver services and suspension or revocation of their authorization to receive Medicaid funding.

*Budget and Finance Team*. The Budget and Finance Team is responsible for providing budgetary support to the Division, the fifteen institutions operated by the Division, and the LME's. The nine member Team is responsible for determining the allocation of waiver funding,

monitoring the utilization of waiver funds to ensure optimum participation and monitoring total Medicaid expenditures for waiver participants to ensure cost neutrality.

Advocacy and Customer Services

*Consumer Empowerment Team (CE Team).* The CE Team encourages and coordinates consumer involvement in provider, LME and state level planning activities. This team has five full time and one half time regional members who act as liaisons to local and state consumer and family advisory committees (CFACs), provide technical assistance as needed, and coordinate advocacy activities.

*Customer Services and Consumer Rights Team (CSR Team).* The CSR Team receives and responds to individual inquiries and complaints about access to and quality of services. The six members of this team work closely with the QM and Accountability Teams to determine when DMHDDSAS needs to intervene in or assist the LME in addressing individual situations.

## Responsibilities of Local Management Entities (LME's)

The Local Management Entities (LME) are the local lead agencies for the counties they serve, and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

- Local business planning to ensure congruence with the State Business Plan for MHDDSA Services
- Governance, management and administration
- Development of a community of qualified providers
- Service management, including utilization review and Plan of Care approval
- Operation of a uniform local access system
- Service monitoring and oversight
- Evaluation and continuous quality improvement
- Financial management and accountability
- Management of secure information systems with data on consumers, providers services and finances
- Coordination of collaboration among community agencies and organizations

The LME must assure that the policies and procedures for the waiver and all programs in the public MH/DD/SA service system are followed. They are responsible for the health, safety and welfare of individuals receiving services, for assuring integrity and improvement of the provision of services and supports with the Plan of Care, and for assuring that individuals receive the appropriate level of care, including ICF-MR level of care under the proposed waiver.

In their role of local managers of public policy, LME's are responsible for oversight of providers operating in their counties as well as those providers with whom they contract for services in other counties. LME's are currently in the process of divesting of services previously provided within their agencies as part of their former roles as community MH/DD/SAS programs. Until

this divestiture is complete the DMHDDSAS Accountability Team retains responsibility for monitoring waiver and other services provided by the LME.

### *LME Performance Contract*

DHHS oversees the management and provision of local services through a Performance Contract with each LME that is renewed annually. The contract is signed by the Secretary of the Department and is developed jointly by the Divisions of MHDDSAS, Medical Assistance and the Office of the DHHS Controller. The contract includes both statewide requirements reflecting the LME functions outlined above and locally specific requirements, which are set forth in each LME's Local Business Plan. The Performance Contract includes the following requirements that relate generally or specifically to the Waiver program:

- Maintain full lead agency status for the Waiver
- Manage services according to applicable rules, rates and procedures
- Assess compliance with service provision, documentation, and reporting requirements, and with fiscal and accounting requirements (this includes the waiver manual and the Medicaid manual and service guidelines)
- Use quality improvement processes to improve the service delivery system
- Implement reasonable or agreed upon corrective actions and management improvements required by the Secretary of DHHS or resulting from audits, program reviews, or quality improvement processes (including Medicaid audits, local single audits, Federal program audits, State program reviews, and accreditation visits and reports)
- Provide individuals and families an understandable and user-friendly intake and eligibility process.
- Participate in the Developmental Disabilities Consumer Outcome Inventory Project and National Core Indicators Project (methods by which waiver participant feedback and input is received, consumer outcomes are measured and problems with access to services are identified.)
- Complete the NC-SNAP (an evaluation tool used for utilization management)
- Participate in the Integrated Payment and Reporting System (the information management system to track service utilization, funding sources, and costs)

The contract includes statewide performance measures in each functional area that are analyzed and reported publicly by the DMHDDSAS QM Team each quarter. This information is reviewed by the Executive Leadership Teams of DMHDDSAS, DMA and Office of the DHHS Controller. Within DMHDDSAS the information is also reviewed by the Management Leadership Team, and LME Team to identify potential problems and to determine areas in which technical assistance or state intervention is needed. In addition, LME's, their county commissioners, and local CFACs use the information in these reports to evaluate and improve local performance.

### *NC Council of Community Programs*

The NC Council of Community Programs (NCCCP) is an association of the LME's that works closely with DMHDDSAS to coordinate LME input into policy decisions. The NCCCP hosts

several quarterly forums that bring LME staff together to discuss means of implementing DMHDDSAS policy decisions. The QI Forum, Consumer Rights Forum and Provider Relationship Leadership Forum are instrumental in such tasks as developing statewide forms and procedures for reporting consumer incidents and complaints and developing provider monitoring tools and reports. In addition, some of the LME's contract with the NCCCP to conduct provider certification reviews and/or local monitoring of providers.

## Responsibilities of Provider Agencies

### *Plan of Care and Case Management*

Targeted Case Management services will be provided to individuals participating in this waiver through the State Medicaid Plan. Case managers must be Qualified Professionals or Associate Professionals working under the supervision of Qualified Professionals within a provider agency. In the past, Case Management services have been provided as a part of the waiver array of services with the local lead agency being the primary provider of case management services. LME's are in the process of divesting themselves of services including case management. Targeted Case Management provides for a single Case Management definition rather than a separate definition for individuals on the waiver and those who are not waiver recipients. In addition, the move to Targeted Case Management through provider agencies allows for greater choice in case management service providers, and to avoid conflict of interest, establishes the limitation that provider agencies may not provide Targeted Case Management and waiver services to the same person.

The Case Manager has the overall responsibility of developing the Plan of Care in partnership with the individual and their family. In addition, they are responsible for ordering, coordinating, and monitoring waiver services, and monitoring all aspects of service delivery.

### *Quality Improvement*

The requirements for a provider to deliver MH/DD/SAS services in NC include having and implementing a quality improvement plan and process within its agency. In the past, small providers contracted to an LME have used the LME's QI process to fulfill this requirement. However, as LME's transition from being service providers into becoming management entities, most are requiring private providers in their community to develop independent internal QI processes.

### *Client Rights Committees*

Providers are also required to have client rights committees that are responsible for protection of client rights and confidentiality .The LME transition is also requiring small providers to develop internal Client Rights committees, rather than relying on the LME's committee as a way to fulfill the requirement.

## Responsibilities of Consumers and Family Members

### *Consumer and Family Advisory Committees (CFACs)*

The State Business Plan for MHDDSA Services requires each LME to solicit and attend to consumer input into service planning, delivery and oversight. Within each LME's area, an

independent committee composed of consumer and family representatives (Consumer and Family Advisory Committees or CFACs) from each disability/age group is charged with:

- Advising and commenting on all state and local plans
- Making recommendations on areas of service eligibility and service array, including service gaps
- Assisting in identification of under served populations
- Providing advice and consultation in development of additional services and new models of service
- Participating in monitoring of service development and delivery
- Reviewing and commenting on state and local service budgets
- Observing and reporting on the implementation of state and local business plans
- Participating in all quality improvement activities, including tracking and reporting on outcomes measures and performance indicators
- Ensuring consumer and family participation in quality improvement projects at the provider and LME level

These committees are becoming involved in the evaluation and reporting of LME and provider performance by providing input into the contents of provider performance reports and the LME's' quarterly update on implementation of their local business plans. In addition, the CFACs will assist in the evaluation of LME and provider performance through a mystery shopper program to assess timely, respectful, and effective response to requests for services.

Consumers and family members are represented at the state level through a state CFAC. This committee, composed of rotating members appointed by the Secretary of DHHS, provides input into state policy making and ensures that consumers and family members also have a voice in local decisions. The state CFAC plays an active role in QI activities, including:

- Advising and commenting on all state and local plans.
- Providing recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assisting in the identification of under-served populations.
- Reviewing and commenting on the state and local service budgets.
- Observing and reporting on the implementation of State and Local Business Plans.
- Participating in all quality improvement activities, including tracking and reporting on outcome measures and performance indicators.
- Ensuring consumer and family participation in all quality improvement projects at both the provider and LME levels.

## Design of the Quality Management System

Development of a quality management system is one of the fundamental building blocks of MH/DD/SAS reform in North Carolina. It is the intent of the State MHDDSAS Plan that quality management systems integrate and analyze information from multiple sources and functions within the state service system. Quality Management processes must be accountable to all stakeholders and findings must be published, including the assessment of quality improvement activities. The specific objectives related to Quality Management are:

- The Division will develop and execute a comprehensive quality management system focusing on continuous quality improvement.
- The quality management system will be outcome-based.
- Performance indicators for all levels of the system will be included in the quality management process.
- The Division will develop measurement criteria for models of best practice to be included in the QM system.
- The Division will establish competency requirements for all segments of the mental health, developmental disabilities and/substance abuse services workforce.
- The Division will manage a comprehensive training and education strategy to support the new quality management system.

The QM system is being redesigned using the Home and Community-Based Services (HCBS) Quality Framework as a part of this system. The QM Team has identified measures within each of the framework's domains that correspond to the goals of the State Business Plan for MHDDSA services. Some of these measures are currently collected, analyzed, reported and reviewed as part of the LME Performance Contract. Mechanisms for regular collection, analysis and review of data on the other measures are currently being devised. Although these measures are not fully developed or implemented they are attached to this document.

### Real Choice Systems Change Grant for QA/QI in HCBS

The QA/QI grant awarded from CMS in 2003 is being used to plan and pilot mechanisms to identify problems and successes and improve structures, processes and consumer outcomes.

People transitioning from state facilities into community settings as part of the state's Olmstead plan, will be interviewed by paid consumer and family interviewers to gather information on individual needs, progress toward personal goals, functional outcomes, and satisfaction with the transition process. Two face-to-face interviews and two phone interviews over the course of the individual's first year in community will provide the initial focus and data for the Division to develop and implement processes to review individual data, rectify immediate problems, prevent future problems, and build on successes. It will also serve as a means to develop and implement structures and processes for ongoing QI, including the training of provider staff, families, consumers, and other stakeholders in the philosophy and methods of QI.

Through the grant, the Division will enhance processes and coordination among QI Committees at the Provider, LME, and State levels with the inclusion of consumers at all levels. The QI committees will review data to identify areas for improvement, oversee development,

prioritization, and implementation of improvement projects, identify needed resources, and evaluate the impact of projects to ensure that identified problems are resolved, services are provided satisfactorily and successful improvements are rewarded.

## Information Systems

In addition to consumer-specific data to be collected through the grant activities, DMHDDSAS routinely collects data on service utilization and costs, consumer outcomes and satisfaction, and special projects. The following list provides an overview of data available for use in the QM system.

| System | Purpose | Status for Waiver Participants |
|---|---|---|
| Integrated Payment and Reporting System (IPRS) | Service utilization and claims data for state funds. The IPRS is used to track, pay and report on claims submitted by providers for services rendered. Area programs/LME's submit a single claim to the state, and the IPRS processes the claim from the appropriate funding source: Medicaid, DMHDDSAS funds or capitated risk contracts. | In use |
| Medicaid Management Information System (MMIS) | Service utilization and claims data for Medicaid funds | In use |
| (HEARTS)Healthcare Enterprise Accounts Receivable and Tracking System | Billing system used for state operated facilities. Service utilization and consumer descriptive and outcomes information for state operated facilities | Applies only to individuals in state institutions |
| Client Data Warehouse (CDW) | Consumer demographics and descriptive information | In use |
| Decision Support Information System (DSIS) | Integrated consumer data from other data sources | In development |
| Automated Incident System | Consumer-specific information on deaths, abuse, restrictive interventions, and other incidents | In development |
| National Core Indicators (NCI) | Consumer outcomes and satisfaction information | In use |

| | | |
|---|---|---|
| Developmental Disabilities Consumer Outcomes Inventory (DD-COI) | Consumer outcomes and satisfaction information | In use (to be replaced by NC TOPPS) |
| Olmstead Outcomes | Consumer outcomes and satisfaction for Olmstead populations | In use |
| NC SNAP | Assessment tool for DD populations | In use |
| NC TOPPS | Web-based consumer outcomes and satisfaction information | In development |
| MMIS+ | Integrated service utilization and claims data for state and Medicaid funds | In development |
| Health Information System (HIS) | Integrated DHHS information system | Planned |

In addition to these major systems, DMHDDSAS has access to department-wide provider and individual-specific data, including sanctions against licensed providers, substantiated abuse charges against health care personnel, and vital records.

The following tables provide a reference for the overall quality management system. Table 1 presents the components of the three-tiered North Carolina DMH/DD/SAS quality management system. Table 2 presents the measures that DMH/DD/SAS is currently using or plans to use to measure system performance as they relate to this framework.

## Table 1. Overall Quality Management System

| | Providers | LME | Consumers | State/System |
|---|---|---|---|---|
| **DESIGN** | • Licensure<br>• Medicaid enrollment<br>• Person-centered plan & service authorizations<br>• Evidence-based practices<br>• National Accreditation | • National accreditation<br>• Target populations<br>• Consumer & family advisory committee | • Choice<br>• Person-centered plan | • Statutes/rules<br>• DMH/DD/SAS teams<br>• Training<br>• Best practices<br>• Data systems<br>• Evaluation plan |
| **DISCOVERY** | • Local monitoring<br>• DFS review<br>• Complaint investigations<br>• Medicaid audits<br>• Accrediting body reviews (if applicable) | • Utilization review<br>• Performance reviews (on-site visits, submitted reports, submitted data)<br>• Sub-recipient/fiscal monitoring<br>• Accrediting body reviews (if applicable) | • Incident system<br>• Complaint system<br>• Appeals system<br>• NC TOPPS / COI<br>• Consumer Satisfaction Survey<br>• IPRS<br>• CDW/CSDW<br>• Case management | • Federal audit<br>• State audit<br>• Block grant measures |
| **Reports and Analyses** | **Providers** | **LME's** | **Consumers** | **State/System** |
| | • Profiles<br>• Performance reports<br>• Audit reports<br>• Investigation reports<br>• Accreditation status (if applicable) | • Performance reports<br>• Monitoring reports<br>• Audit reports<br>• Accreditation status | • Review of individual reports and surveys shown above | • Performance reports on outcomes, fiscal, consumer perceptions, and process (e.g. fidelity to evidenced-based practices) |
| **REMEDIATION** | **Re: Provider Issues**<br>• Corrective actions<br>• Suspension / revocation of: license, billing authority, LME endorsement or contract<br>• Medicaid paybacks | **Re: LME Issues**<br>• Accountability to local government<br>• Medicaid paybacks<br>• Corrective actions from the state or accrediting body<br>• Technical assistance | **Re: Consumer Issues**<br>• Person-centered plan changes<br>• Service authorization changes<br>• Appeal decisions<br>• Case management | **Re: State/System Issues**<br>• Federal government technical assistance<br>• Paybacks<br>• DMH/DD/SAS technical assistance |

| | | | | | | |
|---|---|---|---|---|---|---|
| **QUALITY IMPROVEMENT** | Provider QICs + LME QIC | = Local QICs + | DMH/DD/SAS State Facility QICs + Central Office QIC | = State MH/DD/SAS QIC | + representatives from DSS, DFS, DMA, DOA & other DHHS divisions as needed + representatives from DPI, DOC as needed + representatives from CFACs | = DHHS QIC |

QIC = quality improvement committee

**Table 2. HCBS quality framework measures for CAP MR/DD waiver**

| Domain | Desired Outcome | Item | Status | Suggested Reporting Frequency |
|---|---|---|---|---|
| Participant Access | Individuals have ready access to home and community-based services and supports in their communities. | Services received (units, $) | Currently in use | Q |
| | | Target populations served | Currently in use | Q |
| | | Penetration rates | In development | Q |
| | | **Timely access** | **In development** | **Q** |
| Person Centered Planning and Service Delivery | Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. | **Discharge/after care planning and service coordination** | **Currently in use** | **A** |
| | | **Informed choice about providers** | **In development** | **A** |
| Provider Capacity and Capabilities | There are sufficient providers and they possess and demonstrate the capability to effectively serve participants. | **Utilization of state institutional care** | **Currently in use** | **Q** |
| | | **Distribution & types of community-based services** | **In development** | **Q** |
| | | Provider performance | In development | |
| | | Availability of and fidelity to best practice models | In development | |
| Participant Safeguards | Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices. | **Critical incidents** | **Currently in use** | **Q** |
| | | **Medication management** | **Currently in use** | **Q** |
| | | **Restrictive interventions** | **Currently in use** | **Q** |
| Participant Rights and Responsibilities | Participants receive support to exercise their rights in accepting personal responsibilities. | **Rights information (service denial notifications)** | **Currently in use** | **A** |
| | | **Complaints and appeals (# and types)** | **Currently in use** | **Q** |
| Participant Outcomes | Participants achieve desired outcomes. | Clinical outcomes, improved function | Currently in use | A |
| | | Community inclusion | Currently in use | A |
| | | Criminal justice/Juvenile Justice involvement | Currently in use | A |
| | | Employment/school | Currently in use | A |
| | | Housing (independence and safety) | Currently in use | A |
| | | Personal goals outcomes | Currently in use | A |
| | | Quality of life indicators, well-being | Currently in use | A |

| | | | | |
|---|---|---|---|---|
| Participant Satisfaction (with system and processes) | Participants are satisfied with their services. | Access | Currently in use | A |
| | | Appropriateness | Currently in use | A |
| | | Respect/courtesy | Currently in use | A |
| | | Services and supports | Currently in use | A |
| System Performance | The system supports participants efficiently and effectively and constantly strives to improve quality. | **Financial integrity** | **Currently in use** | **Q** |
| | | **Information systems and monitoring capabilities** | **Currently in use** | **Q** |
| | | Quality Assurance process (audits and provider monitoring) | Currently in use | Q |
| | | Utilization Management/Review (high costs, denials or adjustments) | Currently in use | Q |
| | | Quality Improvement process (local) | In development | A |
| | | **Participant and stakeholder involvement (CFAC)** | **In development** | **Q** |
| | | Quality Improvement process (state) | In development | |

Bold items are included in the LME Performance Contract (along with other measures)
Frequency = Q (quarterly), S (semi-annually) or A (annually)

## Level of Care Determination

### Design

Individuals referred for waiver funding will have their level of care assessed by a licensed psychologist or physician as appropriate. The LME will make the determination of Level of Care. The results of the determination will be made on the MR2 form. The Behavioral Health Unit of DMA conducts quality assurance reviews that include a review of the application of eligibility criteria for individuals participating in the Waiver.

#### *Access to Services*

LME's are required through Performance Measures in the LME Performance Contract to provide a system of access and triage to services in a prompt, user-friendly manner. The LME must ensure geographic access to supports and services. Geographic location of providers must cover the entire populated catchment area to provide crisis, assessment, case management, outpatient therapy, and periodic waiver services. Eligible persons must have access to face-to-face service (assessment and/or treatment) within 2 hours of the request for care in emergency situations, 48 hours for urgent situations, and within 7 calendar days for routine care. This includes individuals who are potentially eligible for waiver services, assuming that the individual meets the ICF-MR level of care. Individuals in the developmental disabilities target populations are assessed for other MH/DD/SAS specialty services, placement in an ICF-MR or other setting, or referral to other community services as appropriate.

#### *Initial Level of Care Determinations*

The eligibility determination process is the first step in the development of the person centered Plan of Care. It is designed to determine eligibility but also to initiate the process of understanding each participant's unique needs and initial goals regarding their life in the community. Level of Care determinations for the waiver and for ICF-MR level of care for placement are made based on the MR2; a North Carolina Medicaid Program eligibility form. The MR2 includes information about diagnoses, medical concerns, nutrition, skin, ambulation, functional limitations, personal care issues, supportive devices, behavioral problems, and the plan of treatment. Information included on the MR2 must be consistent with and supported by corresponding evaluations. The case manager, in collaboration with the individual/family, is responsible for coordinating any evaluations and other information required to complete the Level of Care form. This form must be signed by a physician or licensed psychologist on the initial level of care determination.

#### *Redetermination of Level of Care*

Redetermination of level of care or Continued Need Reviews (CNR) must be provided by a qualified professional. The Continued Need Review or re-evaluation must be completed annually during the birth month of the individual. This activity is an integral part of Targeted Case Management required activities, which are the responsibility of a Qualified Professional. Pending recommendations of level of care, the LME will complete the final determination for continued authorization of Level of Care and Medical Necessity.

**Discovery**

The LME reports quarterly the number of persons requesting service for urgent and routine needs, the percent determined to need emergent, urgent and routine care and of those, the percent for which care is initiated within the required timeframes. DHHS reviews a random sample of up to 20 urgent services annually to verify accuracy of the information.

The proposed waiver provides for initial Level of Care reviews to occur at the Local Management Entity level as part of the Utilization Review and Authorization process. Utilization Review and Authorization of services is provided by a Qualified Developmental Disability Professional trained and competent to approve Plans of Care. Quarterly monitoring of the local approval or authorization process is provided by the Program Accountability Team. Annually the Program Accountability Team and DMA's Behavioral Health Unit conduct a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of individual directly enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. In addition, the Behavioral Health Unit of DMA conducts quality assurance reviews monthly that include a review of the application of eligibility criteria for individuals participating in the waiver. Each month DMA selects a random sample of waiver cases that were active on the last day of the review month. Reviews occur either on site or the records are sent to DMA for a desktop review. The reviewer looks for a current MR2, documentation that the client is at risk of institutionalization or was de-institutionalized, where the individual resides while on the program, and a current, approved Plan of Care.

Reauthorization of Level of Care must be done annually through Utilization Review at the LME in conjunction with the development of the Annual Plan of Care to assess the individual's progress. This will result in determination of continuing eligibility for ICF-MR level of care. If the LME decides a second level review is needed, a physician or licensed psychologist will complete a new MR2. Evaluations to support the MR2 must be available for review. As noted above, quarterly monitoring of the local approval or authorization process is provided by the Program Accountability Team. Annually the Program Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of individual directly enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. In addition, the Behavioral Health Unit of DMA conducts quality assurance reviews monthly that include a review of the application of eligibility criteria for individuals participating in the waiver. Each month DMA selects a random sample of waiver cases that were active on the last day of the review month. Reviews occur either on site or the records are sent to DMA for a desktop review. The reviewer looks for a current MR2, documentation that the client is at risk of institutionalization or was de-institutionalized, where the individual resides while on the program, and a current, approved Plan of Care.

**Remediation**

The following process occurs as a result of DMA quality assurance reviews:

- DMA will e-mail a preliminary report to Resource/Regulatory Management at DMH/DD/SAS at the conclusion of each month's review. It will note the specific deficiencies (if any) that are found in each case. If the reviewer notes problems in LME/Area Authorities that could be placing consumers in jeopardy of health, safety, and well being, Resource/Regulatory Management will be contacted by phone immediately for intervention.
- Based on the findings from reviews, DMA may request Resource/Regulatory Management to submit corrective action plans within 30 days of the date of the report letter.
- Resource/Regulatory Management may request DMA to reconsider any finding included in the report. The request and all supporting documentation must be received by DMA within 30 days of the date of the report letter.
- DMA will send Resource/Regulatory Management a final report within two weeks from the receipt of the reconsideration request and supporting documentation.
- An annual report will be prepared by DMA and will site the specific deficiencies that were found in reviews. This annual report becomes part of the annual HCFA-372 report.

Failure to comply with an annual level of care re-determination during the birth month of the individual will result in termination of services, and denial of claims for services after the CNR month.

As part of the Fair Hearing Process, each participant will receive a copy of their rights at the time of eligibility screening for home and community based waiver services. In addition, persons who are not given the choice of home and community-based services as an alternative to ICF-MR care or choose, but are not given, home and community based services as an alternative to ICF-MR care, or who are denied the service or provider of their choice are verbally notified of their right to a fair hearing. Each LME or designated Lead Agency will have in writing the appeal process at the local and state level, which contains, at a minimum:

- The right to a Fair Hearing;
- The method for obtaining a Fair Hearing;
- The rules that govern representation at Fair Hearings;
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the individuals can use to file a Grievance and/or Appeal by phone;
- Rights, procedures and timeframes for voicing or filing Grievances and Appeals or recommending changes in policy and services.

As part of the Performance Contract, LME's are expected to adhere to their processes outlined in their QM Plan. Attachment 3 of the Performance Contract outlines performance standards against which LME's are measured, including Access and Triage standards. As an additional component of the local QM process, each LME has a QM program manager that oversees the local QM plan and monitors progress toward indicators. Program managers insure that data is gathered for submission of required quarterly reports to the Division. Quarterly reports are submitted to the respective LME Team liaison of the Division of MH/DD/SAS with actual data submitted to the Quality Management Team of the Division. Data collected on measures of system performance includes:

- Provider capacity and geographic coverage
- Service penetration and timeliness
- Participant choice in providers
- Participant involvement in service planning, delivery and oversight
- Fiscal responsibility

Areas of concern may result in technical assistance from the LME Team. For LME's unable to meet the State expectations for their QM Plan, technical assistance may be provided through the Quality Management Team.

***Future Plans:***

The proposed waiver calls for level of care determination to occur at the local level with the LME. As a result, we recognize the need to provide greater assurance of the accuracy of the determinations. DMA's Behavioral Health Unit, in conjunction with the Division's Program Accountability Team is currently revising the slate of issues to address, with the goal of concentrating on the quality of services/treatment provided. This will be done by relying more heavily on the clinical aspects of the service definitions as the basis for audit questions, and by renewed diligence in reviewing service logs for appropriate documentation of time spent and activity variables for each service event. In addition, the Division will ensure that Level of Care reviews continue to occur during the quarterly Program Accountability reviews.

**Quality Improvement**

Measures to be tracked that correspond to the HCBS Quality Framework's Access and Rights and Responsibility domains include the following:

- Target populations served
- ***Timeliness of access (access phone line and time to availability of face-to-face care)***
- ***Prompt notification of service denials***
- ***Types and volume of complaints***
- Use of complaints data to identify and respond to local trends
- Results of mystery shopper
- Services provided to target and non-target populations
- Service penetration rates

NOTE: All measures will be reviewed by the MLT as part of its QI activities. Measures listed in ***bold italics*** are also reported publicly as part of the LME Performance Contract reports. The QM Team produces periodic reports on service utilization and costs by LME. These reports are distributed to local stakeholders and made available to the public on the DMHDDSAS website.

## Plan of Care

### Design

This waiver application proposes to lift the individual budget limitation. LME's are provided a global waiver "virtual budget" (allocation) by DMH/DD/SAS along with an expectation that a minimum number of individuals be enrolled in the waiver each year. The waiver funds are referred to as a "virtual budget" because no money actually transfers to the LME's' accounts for expenditures. Reimbursement for waiver services is paid directly to service providers by the Medicaid agency upon the submission of clean billing claims. The allocation is based on the historical and projected cost of waiver participants within the catchment area served by the LME. LME's are required to establish internal reporting mechanisms to track use of waiver funds. DMH/DD/SAS monitors the status of the LME's virtual budgets by using information from the Medicaid Paid Claims Information System. State information is shared with LME's on a monthly basis.

This waiver further proposes that Lead Agencies must adhere to the standardized, statewide Utilization Review process and criteria established by DMH/DD/SAS, and approved by DMA, and to the family or person-centered planning process established by the State Business Plan for MHDDSA Services.

### Discovery

The Case Manager has the overall responsibility for developing the Plan of Care in partnership with the individual/family which meets the unique needs, expressed preferences and outcomes concerning each consumer's life in the community. In addition, they are responsible for ordering, coordinating, and monitoring all aspects of service delivery. Targeted Case Management services will be provided to individuals participating in this waiver through the State Medicaid Plan. Case managers must be Qualified Professionals or Associate Professionals working under the supervision of Qualified Professionals within a provider agency. In the past, Case Management services have been provided as a part of the waiver array of services with the local lead agency being the primary provider of case management services. LME's are in the process of divesting themselves of services including case management. Targeted Case Management provides for a single Case Management definition rather than a separate definition for individuals on the waiver and those who are not waiver recipients. In addition, the move to Targeted Case Management through provider agencies allows for greater choice in case management service providers, and to avoid conflict of interest, establishes the limitation that provider agencies may not provide Targeted Case Management and waiver services to the same person.

#### *Case Management Discovery Processes*

The Case Manager monitors Plan activities in relation to a person's situation and as stated on the Plan of Care. The monitoring schedule must be sufficient to assure the health, safety and welfare of the person and must be outlined in the Plan of Care. This includes at least one face-to-face contact with the waiver recipient monthly. Through observation, interview, and documentation review, the Case Manager monitors for progress, lack of progress, individual's satisfaction with services, health, safety and welfare and need for service changes. The Case Manager also monitors the cost of the Medicaid State Plan services as part of the responsibility to maintain cost-effectiveness.

### *LME Discovery Processes*

The LME monitors the overall cost of services to all waiver participants in its catchment area to ensure cost-effectiveness, as part of its service management and quality improvement functions. Each LME's waiver allocation is based on the historical and projected cost of waiver participants. LME's are required to establish internal reporting mechanisms to track use of waiver funds. DMH/DD/SAS monitors the status of the LME's virtual budgets by using information from the Medicaid Paid Claims Information System. State information is shared with LME's on a monthly basis.

To ensure cost effective and appropriate Plans of Care, a Utilization Review Tool is currently being developed. This Utilization Review Tool and process is anticipated to be in place at waiver implementation. The LME's' utilization review specialists will authorize plans of care using the Utilization Tool and process to insure that consumers are achieving goals and receiving the appropriate services and supports to meet their unique needs and preferences.

Plans of Care must meet the following elements:

- Comprehensive data regarding the individuals/family's preferences and personal goals, needs and abilities, health status as well as other available supports, are gathered with the individual/family and used in the development of a person centered plan.
- Information and support is available to assist individuals and families to make informed choices regarding service options.
- Information and support is available to assist participants to make free and informed choices among qualified providers.
- Each individual's plan comprehensively addresses their identified need for supports, health care and other services in accordance with their expressed personal preferences and goals.
- Individuals and families have continuous access to assistance as needed to obtain and coordinate services and quickly address issues encountered in community living.
- All services and supports are provided in accordance with the individual or family's plan.
- Regular, systematic and objective methods, primarily individual or family feedback, are used to monitor the individual's well being, health status, and the effectiveness of supports and services in enabling the individual to achieve their personal goals.
- Significant changes in the individual or family's circumstances promptly trigger consideration of modifications to the person-centered plan.

### *DMHDDSAS Discovery Processes*

Quarterly monitoring of the local approval or authorization process is provided by the Program Accountability Team including review of Plans of Care. Annually the Program Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of individual directly enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, service plans or Plans of Care, service documentation, and billing protocol.

### *DMA Discovery Processes*

The Behavioral Health Unit of DMA conducts quality assurance reviews monthly that include a review of the Plans of Care for individuals participating in the waiver. Each month DMA selects a random sample of waiver cases that were active on the last day of the review month. Reviews occur either on site or the records are sent to DMA for a desktop review. The reviewer looks for a current MR2, documentation that the client is at risk of institutionalization or was de-institutionalized, where the individual resides while on the program, and a current, approved Plan of Care to insure that services are appropriate to the needs of the individual. The Plan of Care is further reviewed to insure that services and supports provide for the individual's health, safety and well being. and that services were provided according to the approved Plan of Care during the review month.

These reviews are conducted to assure that the following quality outcomes are achieved:

- Clients approved for participation in the program meet eligibility criteria;
- Clients were given a choice between waiver participation and institutional care;
- Services are cost-effective according to program criteria;
- Services are appropriate to the client's needs;
- Services were provided according to the approved plan of care during the review month; and
- Services and supports provide for the client's health, safety and well being.

The review is also conducted to assure the availability of information and other services in accordance with the individual's expressed personal preferences and goals, that services are appropriate to the individual's needs and are provided in accordance with the Plan of Care and that the services and supports lead to positive outcomes for the individual.

Other quality outcomes addressed by the review are that there is support to help individuals make informed selections among service option and availability of information and support to assist the individual to freely choose among qualified providers. Additional outcomes are to assure that services are cost-effective according to program criteria, and there is evidence that contingency plans have been established for emergencies and to accommodate backup when formal providers are unavailable.

### *Future Plans*

DMA's Behavioral Health Unit, in conjunction with the Division's Program Accountability Team is currently revising the slate of issues to address, with the goal of concentrating on the quality of services/treatment provided. This will be done by relying more heavily on the clinical aspects of the service definitions as the basis for audit questions, and by renewed diligence in reviewing service logs for appropriate documentation of time spent and activity variables for each service event.

## **Remediation**

The Case Manager is responsible for insuring that any identified needs for changes to the Plan of Care are addressed in partnership with the individual/family.

The LME's' customer services, provider relations and quality improvement units work together to ensure consumers' satisfaction with services and to ensure that services are delivered in

accordance with the requirements of the Waiver service definitions. Serious issues with plans of care may result in temporary suspensions of the LME's permission to conduct local approval/authorization of plans. During suspension, administrative funds are not paid to the agency. The Secretary of DHHS may ultimately reassign lead agency for the waiver for the catchment area, if attempts to address LME problems are unsuccessful.

**Quality Improvement**

Measures to be tracked that correspond to the HCBS Quality Framework's Participant-Centered Planning and Service Delivery domain include the following:

- *Informed choice about providers*
- *Discharge/aftercare planning and service coordination*

NOTE: All measures will be reviewed by the MLT as part of its QI activities as well as reported publicly as part of the LME Performance Contract reports.

## Qualified Providers

**Design**

***Licensure and Certification***

In North Carolina, the Secretary of Health and Human Services is responsible for all licenses of health care facilities, delegating most of this responsibility to the Division of Facility Services. Although providers of periodic services are not currently licensed, waiver funding recipients may live, work, or go to day programming in facilities that are licensed, under NC General Statute 122C, the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. They may also reside in adult care homes licensed under NC General Statute 131D, or in child foster care homes licensed by the Division of Social Services, also under NC General Statute 131D. Under these statutes and Session Law 2002-164, rules have been developed by which licensure is granted. Rules developed in accordance with these statutes provide for written policies for management, admission and discharge criteria, record management, quality assurance and improvement activities, medication administration, reporting of incidents, and other items pertaining to consumer services. Rules also include requirements for facility design and equipment, and personnel.

Other requirements address Supervision of Staff. All staff members are designated as qualified professionals, associate professionals, or paraprofessionals. Their level of supervision requirement is based on this designation. (See *Appendix B- 2* of this Waiver for further information regarding Provider Qualifications.)

Providers that are not required to be licensed must be certified by DMHDDSAS before they can be authorized to receive Medicaid or state funding. The certification process holds providers to similar requirements as licensed providers. The certification process is usually carried out at the local level, either by an LME or the NCCCP under contract with the LME.

All providers must have an endorsement from an LME in the form of either a contract or Memorandum of Agreement before they can be enrolled to receive payment for provision of Medicaid services. This endorsement is based on the provider's licensure or certification status.

### *Criminal Record Checks*

The Provider Criminal Record Check is used to assure that individuals are safe and secure in their homes and communities. Provider agency staff providing services to waiver recipients are required to have criminal record checks, in addition to a self-disclosure requirement of all provider staff. The requirement is modeled after GS 122C-80, Criminal History Record Check Required for Certain Applicants for Employment.

### *Waiver Enrollment*

Minimum requirements of personnel are in place to assure that waiver providers demonstrate the capability to effectively serve individuals. Providers of waiver services must meet the qualifications as outlined in Appendix B-2 of the waiver. In addition, the provider enrollment process assures that services are provided to waiver recipients by qualified agencies. Provider eligibility standards are identified in Appendix B-2 of the waiver, as well as in MH/DD/SAS rule. As a result of reform, a process is currently being designed to address policies and procedures for review of provider qualifications and endorsement of providers. However, our current process is as follows and will be in effect until such time as the policies and procedures for review of provider qualifications are implemented:

- Provider enrollment with DMA documents that the provider agrees to provide services to recipients under the conditions of enrollment. Provider enrollment is a multi step process, which includes the following:
  - Completion of an enrollment packet from DMA
  - Verification by the LME that the following elements are addressed in policies and procedures NOTE: Providers meeting licensure requirements for provided services or accredited by a national accrediting organization or the NC Council of Community Programs are exempt from the review of these items.
  - Confidentiality
  - Client rights
  - Incident reporting
  - Medical preparedness/emergency plan
  - Client discharge from service
  - Client grievance/appeals process
  - Medication administration
  - annual program evaluations, including client satisfaction surveys
  - client record management
  - waiver service definitions/requirements/limitations
  - waiver service documentation requirements
  - equipment purchased with waiver funds for clients
  - staff qualifications

- staff orientation/training
- method of recording staff orientation/training
- clinical and administrative supervision of staff
- medical statements for staff
- staff criminal record and DMV checks
- staff backup plan

- Upon satisfactory completion of the certification review, the LME issues a letter of waiver certificate for the provider addressed to the Program Accountability Section of DMH/DD/SAS.
- Provider agencies not requiring certification letters from the LME send a copy of the application and a copy of the appropriate license to the Program Accountability Section.
- Provider agencies not requiring certification letters from the LME or approval letters from Program Accountability send the original DMA application and a copy of the license to Provider Services at DMA.
- The Program Accountability Team reviews the information and contacts the Provider agency if there are any questions. Once the information is complete, the Program Accountability Team sends a letter to DMA and a copy to the Provider Agency, approving the Provider Agency for the requested services.
- The Provider agency submits the completed Medicaid enrollment application, copy of license/accreditation, and approval letter from the Program Accountability Team, if applicable, to the DMA Provider Services.
- DMA Provider Services notifies the agency if the request is denied or if there are questions.
- Once the Provider agency is approved for enrollment, DMA Provider Services assigns the agency a provider number, notifies the provider in writing of the number and its effective date, and sends the provider agency a signed copy of the participation agreement.
- The Provider agency submits a copy of the document to the LME.

## Discovery

### *Local Provider Monitoring*

LME's are required through statute, rule, and the Performance Contract to develop policies and procedures to monitor providers of residential, day and periodic services licensed under GS 122C, and community-based providers not requiring licensure. These policies and procedures must address the following:

- Receiving, reviewing and responding to incident reports

- Receiving and responding to complaints
- Conducting local monitoring of service provision
- Analyzing and addressing trends identified from the above activities in their QI processes.

Frequency and type of local monitoring is determined by a confidence rating for each provider, assessed through a standardized, statewide evaluation tool. This rating is based on the LME's analysis of:

- the number and severity of incidents reported and the provider response to those incidents
- provider compliance with reporting requirements
- the number of complaints received regarding the provider, provider response to those complaints and conclusions reached about those complaints
- results of reviews conducted by state agencies regarding the provider's compliance with requirements of local service provision
- the addition of a new service
- the provider's status on accreditation by a national accrediting body.

The LME notifies providers of the results of local monitoring within 10 days of the monitoring activity, identifying what was monitored, corrections that are needed, and timeframes for making the corrections, which shall not exceed 60 days from the date the provider received the monitoring report.

**Remediation**

The LME refers licensure infractions, staff abuse and other serious issues identified through monitoring to the appropriate state agency or agencies for investigation, as required by statute, rule or policy. When an LME is incapable of resolving other problems with a provider through the provision of technical assistance or corrective action requirements, the LME can also choose to refer monitoring of that provider to DFS (if licensed) and/or the DMHDDSAS Accountability Team. Under authority of the Secretary of DHHS, DFS can deny, suspend, amend or revoke a license. DMHDDSAS can suspend or revoke a provider's authorization to receive state funding and Medicaid funding (with approval from DMA). It is the intent of the DMH/DD/SAS that actions taken against a provider's licensure or authorization to receive funding will be available for public review on the DHHS website. LME's submit a summary report of monitoring activities to the DMHDDSAS QM Team monthly. This report includes information on providers monitored, whether cited problems have been corrected and if not, an explanation. The LME's also submit a quarterly report to the QM Team giving aggregate information on the types of problems identified in monitoring, trends identified and how LME's are addressing those trends in their QI processes.

The QM Team, LME Team and Accountability Team collaborate to analyze monthly monitoring reports for timeliness of correction of cited problems. If an LME report shows inadequate oversight of providers or an inability to ensure provider improvement, the LME Team liaison to that LME coordinates the provision of technical assistance from Division staff to the LME.

## Quality Improvement

Measures to be tracked that correspond to the HCBS Quality Framework's Provider Capacity and Capabilities domain include the following:

- ***Utilization of state institutional care***
- ***Distribution and types of community-based services***
- Availability of and fidelity to models of evidence-based best practice
- Provider performance

NOTE: All measures will be reviewed by the MLT as part of its QI activities. Measures listed in ***bold italics*** are also reported publicly as part of the LME Performance Contract reports.

The QM Team produces quarterly reports showing trends in provider problems identified across the LME's and how LME's are addressing those trends. These reports are distributed to local stakeholders and made available to the public on the DMHDDSAS website.

# Health and Welfare

## Design

### *Disaster Preparedness, Response, and Recovery Plan*

The Division of MH/DD/SAS has a Disaster Preparedness, Response, and Recovery Plan in place to protect and support individuals in the event of natural disaster or other public emergencies. The plan has statutory authority through NC General Statute 166A-6, The North Carolina Emergency Management Act, Article 1, which states that in a state of disaster, the Governor shall have the power to "utilize all available State resources as reasonably necessary to cope with an emergency, including the transfer and direction of personnel or functions of State agencies or units thereof for the purpose of performing or facilitating emergency services."

In collaboration with State MH/DD/SAS institutions and Local Management Entities, the Division of MH/DD/SAS establishes expectations of the roles that State MH/DD/SAS institutions and Local Management Entities play prior to, during, and in the aftermath of disasters. The Division of MH/DD/SAS will coordinate with other Departments, Divisions and non-governmental organizations to ensure the provision of counseling services to disaster victims; coordinate any necessary the evacuation and relocating of persons with mental health, developmental disabilities, and substance abuse disorders to emergency shelters, special needs emergency shelters, or other residential facilities that accept evacuees; and coordinate with the NC Critical Incident Stress Management Council, to ensure the provision of critical incident management to MH/DD/SAS disaster responders. The Division also provides available personnel and space at state operated facilities to support LME's, depending on the situation.

The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) has delegated operational authority and responsibility for disaster preparedness, response and recovery planning, including training and implementation to the Planning Team Leader who serves in the capacity as Disaster Response Team Leader. The Division's Coordinator of Disaster Preparedness, Response and Recovery (Disaster Coordinator) is a member of the Division's Planning Team and the Disaster Response Team. This individual

serves as the lead contact person between the Division and the State Emergency Response Team (SERT). The Disaster Preparedness, Response, and Recovery Plan serves as a guideline for LME's to develop their local disaster plan to address disasters on a county-by-county basis. The LME's coordinate their disaster plans with state, county and local agencies and governments. Each LME addresses how its consumers will be educated about disaster preparedness, sheltering, obtaining disaster-related services and where to reconnect with the mental health system after the disaster through its Local Business Plan. Each LME will accommodate individuals with special needs.

### *Emergency Plans and Supplies*

Safety and security of the facilities in which individuals receive services are addressed in 10A NCAC 27G .0207, which requires a written fire plan for each facility and an area-wide disaster plan to be developed and approved by the appropriate governing authority [AP/LME]. The plan is available to all staff and evacuation procedures and routes are posted in the facility. Fire and disaster drills in 24-hour facilities are held at least quarterly and repeated for each shift. Each facility has basic first aid supplies accessible for use.

### *Seclusion and Restraint: Training and Policies*

Behavior interventions - including physical restraints - are only used as a last resort and are subject to rigorous oversight. Per Division of MH/DD/SAS policy and administrative rules, *10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions/ 10A NCAC 27E .0108 Training in seclusion, physical restraint and isolation time-out*, prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in methods of preventing and alternatives to use of physical restraint/seclusion/isolation time out. Prior to providing services to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is determined. Training curricula must be competency-based, must include components identified by the State, and must be approved by the State. Service Providers must maintain documentation of initial and annual refresher training, which may be reviewed by State staff at any time.

### *Incident Response System*

Administrative rules requires all LME's and agencies providing mental health, developmental disabilities or substance abuse services to participate in a Division-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues.

Service providers are required to respond to all incidents by:

- Insuring the safety of consumers and others
- Documenting the incident and steps taken to remedy the situation
- Analyzing incident trends as part of the agency's quality improvement process

Incidents are divided into three levels of severity, which determine the intensity and breadth of the response.

- Level I – the least severe – includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
- Level II includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions.
- Level III includes incidents with the most severe and permanent consequences – death or permanent impairment of a consumer or caused by a consumer. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and LME of steps taken.

***Complaints and Appeals***

The Division assures that individuals receive support to exercise their rights and voice complaints about services by having in place a procedure for receiving and responding to complaints. The LME is the local hub for receiving complaints about service provision. Administrative rules requires LME's to ensure that consumers are knowledgeable about their rights and about provider and LME complaint processes. LME's are strongly encouraged to attempt to find informal resolutions to complaints as close to the source of the complaint as possible before activating the formal complaint process.

The Division's Customer Services and Community Rights Team (CSCR Team) and Accountability Team has responsibility for responding to and investigating complaints that come to the state. The CSCR Team is charged with receiving and coordinating response to all complaints that come to the Division. Complaints received by other teams are reviewed to see if they should be addressed first by the CSCRT. Where possible, complaints are resolved locally with the help of the LME customer services office. Complaints to be investigated concern:

- Services are appropriately identified and provided in a timely manner.
- Services are reimbursed in accordance with all State and Federal rules and laws.
- Rights of the persons receiving services from the Division are not abridged in the course of the identification and the provision of those services.
- Component parts of the North Carolina MH/DD/SAS system as represented in applicable State statute and rule, or in the Division's policy function according to those rules, statutes and policies, including adherence to Session Law 2002-164.

A complaint or allegation received by the Accountability Team or by CSCRT is reviewed to see if it meets the criteria to be referred to the LME. If it does not, it may be referred to the appropriate agency or organization (e.g.: DFS; the Governor's Advocacy Council for Persons with Disabilities; the Division of Social Services; the Office of the Attorney General or the appropriate law enforcement agency) for investigation. If the complaint or allegation meets a third set of criteria, it is handled by either the Accountability Team or CSCRT and/or in a joint collaboration of the two teams and possibly one or more of the other agencies mentioned.

The Division may receive complaints or allegations of violations in a number of ways. It is not incumbent upon the person making the complaint or allegation of violation to conform to any prescribed method of formal filing of a complaint or allegation of violation; whereas, it is incumbent upon the Division to receive complaints and/or allegations of violations as they are offered to the Division for action.

### *Client Rights Committees*

Per administrative rule, each area board for MH/DD/SAS services is required to operate at least one Client Rights Committee, and may require contracted providers to operate Client Rights Committees as well. Meetings must be held at least quarterly. NC General Statute 122C-64 states that the Client Rights Committee is responsible for protection of client rights and confidentiality. The statute contains provisions regarding confidentiality, right to treatment and consent to treatment, use of corporal punishment (which may not be inflicted upon any client), use of physical restraints or seclusion; treatment and additional rights in 24-hour facilities; continuity of care for individuals with mental retardation; protection from abuse and exploitation and, the right to advanced instruction for mental health treatment. Administrative rules expound further on the General Statute, and contain further policies on rights restrictions and interventions; information provided to consumers, general civil, legal and human rights; least restrictive alternatives; and rules for 24-hour facilities. Rules further require that an Intervention Advisory Committee be established to provide additional safeguards in a facility that utilizes restrictive (planned as specified in rule) interventions.

## Discovery

Provider agencies handle incidents at level I internally and report aggregate numbers of Level I incidents, identified trends and activities being undertaken to address identified problems to the LME quarterly.

Provider agencies report Level II incidents to the LME within 72 hours. The LME reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities. When there is reason to believe that an adult or child may be abused, neglected or exploited and in need of protective services, the incident is also reported to the local DSS and to the state Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.

Provider agencies report Level III incidents to both the LME and the Division within 72 hours (or immediately if a death occurred within seven (7) days of seclusion or restraint of the individual). LME's report information on Level II and III incidents to the Division quarterly, including aggregate numbers of types of incidents, local trends identified in the LME's analysis and actions they have taken to prevent future incidents.

The CSCR Team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainant and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts. The Division is collaborating currently with LME's to develop a listing of standard elements to be collected for each complaint.

The LME's Client Rights Committee reviews incidents and consumer complaints, including alleged violations of the rights of individuals or groups; cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive procedures, and failure to provide needed services that are available. The Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action. The committee makes recommendations to the Area Board and may make report to local Department of Social Services and other applicable licensing agencies such as Division of Facility Services (DFS), Public Health, and Division of Aging.

Locally mortality reviews are conducted by the Quality Improvement Committee of the LME. Findings include a summary of all individual staff reports and indicate whether the death was a result of any action, or lack of action on the part of program or contract staff. The Quality Improvement Coordinator insures that immediate changes needed within the program are made. If abuse or neglect is suspected in the death of residential consumers, the abuse and neglect complaint is be reported to the Client Rights Committee and to the local Department of Social Services.

The Division Accountability Team and DMA's Behavioral Health Unit ensure the viability of these systems through routine on-site reviews of the LME's' and providers' responses to reported incidents and complaints.

Maintenance of a fully functioning Client Rights Committee is a requirement of the LME in the Performance Contract between the Division and the LME's (see section on Performance Contract). This is monitored through CSCR Team members' analysis of the Annual Client Rights report that is submitted by the LME to the Area Board.

**Remediation**

The LME reviews each Level II and III incident and contacts the provider to ensure that necessary steps are taken to correct problems and prevent future incidents. The LME also analyzes trends in all levels of incidents to determine if intervention is needed. The LME uses this information to determine the frequency and intensity of monitoring needed for a particular provider. (Too few incident reports can trigger monitoring as well as too many.) In addition, the LME can require a provider to submit reports of all Level I incidents for a specified period of time, as part of its effort to monitor and correct identified problems within the provider agency. When an LME is not satisfied with a provider agency's response to an incident or its ability to prevent future incidents, the LME can refer the provider to the Division or to DFS (if licensed).

Division's Customer Services and Consumer Rights Team reviews Level III incidents to ensure that the LME and provider address the situations promptly and effectively. If deemed necessary by this review, the Division Accountability Team may investigate Level III incidents and take administrative action against a provider or LME. Deaths occurring at licensed provider facilities are also reported to DFS, which reviews the incident and works with the Accountability Team to investigate when determined necessary.

**Quality Improvement**

Providers are required to analyze and report incident trends to the LME, as part of their quality improvement process. LME's use incident reporting data, along with other information, to determine the need for on-site monitoring of providers.

LME's, in turn, are required to analyze and report trends in both incidents and complaints to the Division QM Team, as part of their quality improvement process. The Division issues quarterly statewide reports summarizing incidents and complaints, grouped by LME, and describing common trends and activities being taken to minimize the occurrence of adverse events and resolve complaints.

The CSCR Team analyzes data on complaints that come to the state, as well as reports from Client Rights Committees to determine patterns and areas in need of improvement.

The QM Team produces quarterly reports showing trends in incidents and complaints identified across the LME's and how LME's are addressing those trends. These reports are distributed to local stakeholders and made available to the public on the DMHDDSAS website.

Data on incidents and complaints correspond to the HCBS Quality Framework's Participant Safeguards and Rights & Responsibilities domains. Analysis of these data will be reviewed by the MLT as part of its QI activities. In addition, the compliance with the incident and complaint response requirements are reported publicly as part of the LME Performance Contract reports.

The statewide incident response system is entering its second year of implementation. In addition to review by the MLT, the Division is creating a state level committee with representatives from providers, LME's, consumer advocates, and DHHS to review incident trends and coordinate statewide improvement activities to minimize incidents and their impact on consumers. The Division is also developing a statewide database for managing and sharing incident information, with a web interface to streamline reporting. The statewide database will improve the timely coordination and oversight of incident response and facilitate the analysis of incident data to identify problems and opportunities for improvement.

Measures to be tracked that correspond to the HCBS Quality Framework's Participant Safeguards domain include the following:

- *Critical incidents*
- *Medication management*
- *Restrictive interventions*

NOTE: All measures will be reviewed by the MLT as part of its QI activities as well as reported publicly as part of the LME Performance Contract reports.

## Administrative Authority

### Design

In addition to the quality management systems described above, DMA and DMHDDSAS cooperate in overseeing the programmatic aspects of the waiver. DMA retains the responsibilities of approving all policies, rules and regulations concerning the waiver and oversees the operation of this waiver program. DMA has the right to impose penalties, sanctions, or arrange for temporary management of the waiver. DMA ensures accountability and effective management of the waiver. DMA also reviews the results of the Division's Quality

Management activities related to the waiver. As part of its oversight responsibilities, DMA conducts a Quality Assurance Program to routinely monitor and evaluate the plan of care review and approval activities. It is a Federal requirement that the waiver Plan of Care is subject to DMA review and approval. DMA has delegated approval authority to the Division of MH/DD/SAS and to LME's. As previously noted the QA Program is conducted to insure that:

- Clients approved for participation in the program meet eligibility criteria;
- Clients were given a choice between waiver participation and institutional care;
- Services are cost-effective according to program criteria;
- Services are appropriate to the client's needs;
- Services were provided according to the approved plan of care during the review month; and
- Services and supports provide for the client's health, safety and well being.

DMA's Program Integrity Unit conducts reviews to assure compliance with requirements in regard to appropriate use of Medicaid dollars. Please see the Financial Accountability Section of this document for this process.

**Discovery**

In addition to on-site reviews and investigations conducted by DMA and DMHDDSAS Accountability Team, the Division collects data on consumer services and costs through the IPRS and MMIS. These data include demographic, diagnostic and service utilization data on all consumers receiving waiver-funded and/or state-funded services. While these data systems are designed primarily for oversight of fiscal operations, the QM Team analyzes them to evaluate consumers' access to services and the volume and cost effectiveness of services received.

The Division collects consumer characteristics, outcomes and satisfaction with services through the Central Data Warehouse (CDW), Developmental Disabilities-Consumer Outcomes Inventory (DD-COI) and the National Core Indicators (NCI). The CDW contains descriptive information on all consumers served by the state, including waiver participants. The CDW functions as the hub for linking various databases with client-specific data, including data from other state agencies.

The DD-COI is an outcome inventory to evaluate a consumer's status in several domains (residence, work/school, safety, community inclusion, and choice) at multiple points in time. It is administered to a 10% sample of consumers who receive publicly funded developmental disabilities services at intake, 3 months, 6 months and annually thereafter. This paper-based system will be replaced in the future by integrating consumers with developmental disabilities into a web-based system that is currently used for consumers receiving mental health and/or substance abuse services (NC-TOPPS).

North Carolina currently administers three of the Core Indicators surveys to collect information on consumer and family/guardian perceptions of and satisfaction with services. The QM Team contracts to have 650 face-to-face surveys administered annually to adult consumers who have a diagnosis of mental retardation. The QM Team mails 2500 surveys to family/guardians of persons with mental retardation. Data are used to compare NC progress with other states who participate in the National Core Indicators.

Under the Real Choice grant, the QM Team will also be collecting outcomes and satisfaction data on persons transitioning from institutional to community-based services. Please see the Design of the QM section of this document for this process.

**Remediation**

COI and CI data and reports are shared with the LME's. The COI data reflects individual indicators. One of the reasons for moving from the COI to the NC TOPPS system is because of the Division's commitment to making TOPPS useful to providers in service planning. CI data currently provides statewide data and cannot be used to show local trends or individual outcomes. The QM team is in the process of increasing the number of face to face CI interviews of consumers in the upcoming survey year in order to provide data that is specific to individual LME's. The QM team will continue developing a system for individualizing the CI reporting so that the data may be used to effect improvement in each consumer's service delivery.

**Quality Improvement**

Data described above correspond to the HCBS Quality Framework's Outcomes and Satisfaction domain. In aggregate, they also are useful for the System Performance domain. The LME Performance Contract reports include measures of compliance with data submission.

In addition to quarterly LME Performance Contract reports, the QM Team produces periodic reports on system performance outside of contract requirements. It also produces periodic reports on consumer outcomes and satisfaction. All of these reports are distributed to local stakeholders and made available to the public on the DMHDDSAS website. Data in these reports as well as other related data will be reviewed by the MLT as part of its QI activities.

Measures to be tracked that correspond to the HCBS Quality Framework's Participant Outcomes, Participant Satisfaction, and System Performance domains include the following:

- Clinical outcomes
- Community inclusion
- Criminal justice/Juvenile Justice involvement
- Employment/school
- Housing
- Personal goals outcomes
- Quality of life indicators, well being
- Access
- Appropriateness
- Respect/courtesy
- Services and supports
- ***Information systems and monitoring capabilities***
- Quality assurance process

- Utilization management/review
- Quality improvement process (local and state)
- ***Participant and stakeholder involvement (CFAC)***

NOTE: All measures will be reviewed by the MLT as part of its QI activities. Measures listed in ***bold italics*** are also reported publicly as part of the LME Performance Contract reports.

## Financial Authority

### Design

The North Carolina General Assembly, in session Law 2001-437, designated the local mental health authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. The local mental health authorities are known as Local Management Entities (LME). Local Management Entities are the local lead agencies for the day to day operations of the waiver in the counties they serve. LME's assure that the policies and procedures for all the programs in the public mental health, developmental disabilities and substance abuse services system are followed, including waiver services. They are responsible for the health, safety and welfare of individuals receiving services, for assuring integrity of the provision of services and supports with the service plan/Plan of Care, and for assuring that individuals receive the appropriate level of care (ICF-MR for waiver services).

LME's are provided a global waiver "virtual budget" (allocation) by DMH/DD/SAS along with an expectation that a minimum number of individuals be enrolled in the waiver each year. The waiver funds are referred to as a "virtual budget" because no money actually transfers to the LME's' accounts for expenditures. The providers bill Medicaid directly for reimbursement of waiver services provided. Reimbursement for waiver services is paid directly to service providers by the Medicaid agency upon the submission of clean billing claims. This assures that payment if made in a timely manner.

The allocation is based on the historical and projected cost of waiver participants within the LME. LME's are required to establish internal reporting mechanisms to track use of waiver funds. DMH/DD/SAS monitors the status of the LME's virtual budgets by using information from the Medicaid Paid Claims Information System. State information is shared with LME's on a monthly basis.

DMH/DD/SAS and DMA jointly ensure that the actual total expenditure for home and community-based and other Medicaid services under the waiver and the claim for FFP in expenditures for the services provided to individuals under the waiver do not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the ICF-MR institutional settings.

The Budget and Finance Team also develops a monthly report that describes the services paid for waiver recipients, the number of units billed, the cost and the number of consumers receiving each service. This data provides the ability to view services paid per individual consumer, as

well as per individual LME or provider. This data may be used in the event that there is a concern or complaint received regarding a specific consumer or provider.

***Medicaid Compliance Audits***

The Division Accountability Team and DMA's Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events per a sample of individual directly enrolled providers. This review includes monitoring of both DMA/Waiver and DMH requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. These reviews assure that documentation and other requirements were followed for services that providers billed to Medicaid and for which they were paid. Although a result of these audits may include payback of funds, DMA is taking unprecedented steps to alter Medicaid audits to address quality and treatment issues. DMA's Behavioral Health Unit, in conjunction with the Division Accountability Team is currently revising the slate of issues to address, with the goal of concentrating on the quality of services/treatment provided. This will be done by relying more heavily on the clinical aspects of service definitions as the basis for audit questions, and by renewed diligence in reviewing service logs for good documentation of time spent and activity variables for each service event.

***DMA Program Integrity Reviews***

DMA Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

**Discovery**

The Medicaid Compliance Audit is conducted using an audit tool created and revised by the Division and DMA. Regular analysis of audit results allows for revision to the tools based on areas of concern that reflect both financial accountability and quality treatment. The annual sample of agencies to be audited takes into consideration compliance from previous years, so that providers with extensive systemic issues will be audited more frequently than those with good to excellent compliance ratings. If a provider has 90% compliance or better they are excluded from the next year's sample. If a provider has 50% compliance or worse, they are automatically included the next year. It is the intent of DMA and the Division to raise the bar on compliance issues by revising audit questions to meet higher quality standards. Discussion with DMA is underway and changes are expected for the Spring 2005 audit season.

DMA Program Integrity Reviews are initiated based on information received from a variety of sources, including:

- Recipients' or family members' complaints about a Provider Agency.
- Reports or complaints from other provider agencies, other state agencies, county agencies or other DMA sections.
- Patterns of practice and use of services identified in Quarterly Surveillance and Utilization Review Subsystem reports of the Medicaid Management Information System that fall outside of the norm for provider agencies' and recipients' peer groups.

- Special computer runs based on reports from referrals to look at specific issues, procedure codes, and possible duplications of services that identify a need for review.
- Identification of a problem with one provider agency that indicates a need to review other provider agencies of the same service in regard to the same potential problem.
- Random sample reviews.
- Areas that Affiliated Computer Services (the agency under contract with DMA to process Medicaid claims) identifies as questionable during claims processing.

**Remediation**

Providers are subject to payback for events found not in compliance during audits, and/or they are subject to written plans of correction for out of compliance issues that are systemic in nature. Submission and determination of paybacks, self-assessments for items requiring more than a single event payback, adjustments and/or recoupment goes through DMA Program Integrity and the Controller's Office. Requests for reconsideration (appeals) also go through DMA Program Integrity and the DMA Hearing Office. Plans of Correction are handled by the Division, and if required, must be approved by DMHDDSAS with follow-up to determine the plan has been implemented occurring within 90 days of the approval date. If a plan of correction is not submitted or not implemented within the identified timeframe, action could follow resulting in termination of the ability to provide services using public monies. Results of the audits are published on the Division's web page.

Program Integrity cooperates with the State Medicaid Investigations unit of the Attorney General and the staff of county Departments of Social Services to identify and investigate instances of fraud and abuse. If the discovery process reveals fraud, a referral is made to the Fraud Unit of the Dept. of Justice. Recoupment of funds or revocation of provider enrollment number may result.

**Quality Improvement**

Fiscal measures to be tracked that correspond to the HCBS Quality Framework's System Performance domain include the following:

- *Financial integrity*

The QM Team produces periodic reports on service utilization and costs by LME. These reports are distributed to local stakeholders and made available to the public on the DMHDDSAS web site.